

## BRIDGING THE GULF OF MEANING

### A PHILOSOPHICAL APPROACH TO PALLIATIVE CARE

The impetus for this paper came from a question asked by a member of the audience during the Second International Seminar on Terminal Care in Montreal in 1978. A panel discussion on meeting the spiritual needs of patients with advanced malignant disease had just ended. Each member of the panel had approached the topic through the framework of an organized religion. The questioner wanted to know how a person who did not share the panel's views could help a patient find meaning in illness or even in death. This paper is an attempt to answer this question. In it I seek to formulate some of the ways in which questions of meaning can be approached. My aim is to uncover a process or framework which might be of use to people who are either inside or outside established religious traditions. In this way, I try to find a philosophy of meaning in the concrete situation which so frequently exists between two people who are connected in one way or another with disease and death.

While my own experience has been that of a volunteer working with patients and families on the Palliative Care Service of the Royal Victoria Hospital, I would expect that the theory presented here will be of use to other members of the health care professions. The volunteer has as a primary goal the establishment of a relationship of friendship with the patient. In a way, not having other professional goals gives the volunteer a certain unique freedom within which to visit and to share in the struggle for meaning that is an inevitable part of the context of serious illness. For this reason, I will present the volunteer as a paradigm 'visitor' and the patient as the paradigm person being visited.

[ The philosophy of the present paper is based upon some observations

about ways in which communication seems to occur in what the philosopher Karl Jaspers calls "life's boundary situations."<sup>1</sup> Serious illness is a turning point. When it is accompanied with the possibility of death a unique opportunity is offered to those who are brought into its domain. It is a basic instinct in life to want to "be fruitful and multiply." This instinct usually takes the form of projecting ourselves into the future through our work, our children, or our dreams. When the stark reality of death looms in front of us a sudden impenetrable wall interrupts our path to the future. Our instincts rebel. We feel that we can no longer be fruitful and multiply. Our thoughts turn backwards instead of forwards. Our work and children become perceived primarily in terms of what we will lose. The structure of meaning that had given shape to our instinct for bearing fruit gets dashed against the wall of death.

The problem for us becomes how to find a new meaning in the days that remain. It is in this context that the instinct to be fruitful and multiply must be turned away from its normal orientation forwards to the future. Instead, it should be focused on a movement inwards. In this way, its structure can become infused with a desire for quality and depth of understanding. This new orientation towards meaning aims to bring about a reorganization within the person of information already present. Ultimately it seeks to build an ordered hierarchy of values which all relate to each other in some pattern that is satisfying to us. This satisfaction can lead to a new peace, born and nourished by living fully in the present moment.

The task that faces many visitors when approaching a patient who is ill and struggling with the question of the meaning of his or her life is how to communicate across the natural barriers which exist between two persons who have

been relative strangers until this moment. If the further goal of this communication is to be not only the relief of physical pain, the supply of nourishment, or the cleansing of wounds, but also the desire to share in the mutual search for meaning, then the gulf that exists is even more awesome. How can this gulf be bridged?

Ideally, the intimacy and intensity demanded in personal talks about meaning should occur in an environment in which the patient is as free as possible from physical pain, is alert, and is able to talk privately without interruptions. For this reason the visitor who is able to enter into a discussion of this sort is dependent upon the other members of the health care team for providing and maintaining this necessary environment. In other words, any attempt to discuss life's meaning must give recognition first to excellence in palliative medical care.

It seems to me to be possible to delineate the following four steps as guidelines in the process of bridging the gulf of meaning. I list them somewhat reluctantly, knowing the abuse which has fallen to the significant five stages that Dr. Koebler Ross delineated in her important work On Death and Dying.<sup>2</sup> The danger in setting stages is that they become interpreted as rigid steps instead of loose guidelines for a process that unfolds at the best of times in its own unique ways.

1. The discovery of common ground.
2. The exploration of differences.
3. The mutual release of energies.
4. The creation of new life.

#### 1. The Discovery of Common Ground

For most experienced visitors one particular patient stands out as having



been special precisely because "he or she seemed so much like us." When some of the main factors present in persons are isolated, the basis for an experience of common bond becomes more obvious. The following is a partial list of some of these factors:

1. Age.
2. Biorhythms (feeling during daily, monthly, and yearly cycles).
3. Socio-economic class (childhood and present).
4. Position and relations within the family (childhood and present).
5. Grief experience.
6. Language(s) spoken and understood.
7. Marital status.
8. Nationality (background).
9. Personality structure (extroverted, introverted, etc.).
10. Regional experience (urban or rural).
11. Sex.
12. State of health.
13. Work or profession.
14. religion

The experience of communication with someone who 'clicks' because of the similarities usually occurs when there are several of the above common factors

present. I remember one woman ~~I felt particularly close to because we were~~ <sup>with whom this bond occurred immediately because</sup> ~~her teacher at Maniampet, we were now both mothers, spoke the~~ <sup>I had been</sup> ~~nearly the same age, were both mothers, spoke the same language, were of a similar economic class, and had the same religious framework within which to interpret life's events.~~ <sup>and I had just bought a house in the same neighborhood, and would soon be joining the same parish.</sup>

However, the instant communication which results from the presence of several common factors occurs infrequently. For the most part, when we meet someone in the hospital setting we are struck at first by a sense of difference that needs to be overcome.

It is useful, therefore, to concentrate on building a foundation in the relationship by seeking out the common ground. This has to be done delicately. The patient has no desire to be interrogated. It is possible, however, through intuition and the information provided by charts to get a sense of what you share with the person before you. When in normal conversation a patient mentions something that you also have experienced (e.g. being the eldest in a family, or being divorced, or being born on a farm, etc.) it is good to pick this information up and reinforce it by divulging to the person your own experiences in that specific area. Similarly, if you learn that something is significant to a patient which is shared by another member of the team, it is good to mention this and offer to make the introduction to the other team member if the patient would like it. This is particularly important in the areas of religious practice, national background, or language.

The establishment of a common ground means that the visitor must be somewhat self-conscious about his or her own specific characteristics, natural or acquired. It is also important to learn how much to share. It takes practice and constant self-evaluation to reach the right balance between divulging so much that the patient is swamped by our information or saying so little that an opportunity for building the foundation for a personal relationship gets lost. It should be added, however, that one of the wonderful aspects of being human is that we can learn through our failures. It is always possible to say in a subsequent session with a patient something like: "In thinking over our conversation of yesterday, I realized that I didn't respond to your comment about... I would like to do so today." Or similarly we can say: "I realize that I talked too much yesterday about myself. I hope it wasn't a burden to you." My experience has been that when a patient realizes you care about the content of a conversation enough to make apologies and new beginnings that it is very much

appreciated. This serves to "turn a failure to the good," and it helps to establish the necessary foundation for building the trust needed to achieve the ultimate goal of bridging the gulf of meaning.

Of course, in situations in which we are visiting persons with a terminal illness, it is sometimes not possible to have the second opportunity to overcome a failure or missed opportunity in communication. In this case, it is helpful to think of the discovery of failure joined to an inner decision to try harder next time as a gift from the patient who died to someone whom you will be visiting in the future. In this way, self-consciousness does not lead to self-deprecation or despair. It is necessary to keep the goal of visiting clearly in perspective. In this phase of the process, the goal is to find and establish a common ground. If this has not been able to be achieved relatively soon, it is advisable, where possible, to reach the decision to not pursue this particular relationship further (at least in connection with the search for meaning). When the visitor is a member of a well integrated team, it is possible to make this lack of success known and to find another person who will be better able to develop the common ground of relationship. When, on the other hand, a common ground has been established it is possible to move to a second stage of relationship.

## 2. The Exploration of Differences

After a solid basis of trust has been established, it is desirable to begin to explore the areas in which we differ as persons. Most obviously one major difference is that while the patient is suffering from the terribly debilitating effects of malignant disease in its final stages, the visitor either has never experienced this kind of disease at all, or else has perhaps recovered from a less fatal version of it. This fact is deeply felt by the patient. If brought into the open, it can be helpful in learning how to under-



stand the person's inner turmoil at the present moment. For example, something like the following can be said: "You know I have never been seriously ill. Therefore, I have no way of feeling inside myself what you must be experiencing, unless you tell me what it is like." If the patient wants to talk about it this will leave open the possibility. If not, then he or she will say something like: "I'd rather talk about something else. It is just too difficult." Immediate acceptance of this decision of the patient is important. It may be that the patient will initiate a discussion on this topic at some later date.

There are so many areas in which differences can be explored. You can learn about a different country, different culture, different religion, different profession, different class, or different perceptions of the opposite sex. One of the important things that happens during this exploration of differences is that the patient becomes able to bring into his or her conscious mind events or patterns in life that have been pushed into the background because of all the struggles and energy that have gone into coping with the illness itself. This is a crucial step in bridging the gulf of meaning. The visitor can help the patient to revalue the ordering of meaning that has occurred through the experience of serious illness. The entire life needs to be put in a perspective that has frequently been distorted by too much preoccupation with disease. When a person comes to terms with the significant events and relationships in his or her past life, it then becomes possible to begin the process of giving a relative value to these things. The presence of another person who is able to lead the patient to a conscious recognition of experiences they have in common as well as the differences that exist between them aids this process very much. Through sharing, the patient becomes able to differentiate himself or herself as a unique person with a unique set of experiences in life.

One of the most helpful books in this area is Man's Search for Meaning by Viktor Frankl.<sup>3</sup> Dr. Frankl discovered through interviews with men and women who survived concentration camps during World War II that these people frequently had something specific to live for. Either they had a person they loved whom they wanted to see, or they had a specific work they wanted to do. Others found a meaning in the transcendence of suffering itself. I have found it particularly useful to apply some of Dr. Frankl's insights to discussions in Palliative Care contexts. Specifically, I have used Dr. Frankl's categories to help a person think back over a lifetime to discover whether or not he or she has ever experienced a "great love" or accomplished a "significant work". If this has been experienced, then it becomes relatively easy to re-establish a memory of these accomplishments. The bringing into consciousness of significant events from the past is an extremely important part of helping a person find a satisfying structure of meaning in the present circumstances of impending death.

Most people who are very ill and aware that they are dying feel overwhelmed by the apparent uselessness of their present life. They feel unable to accomplish any work, quite unlovable, and often that they are a terrible burden to those whom they most love. These feelings are so intense that they tend to overshadow any other aspect of their relationships. They also tend to lead to a rejection of any sense of meaning altogether. It is important then to bring a new perspective into the situation. By focusing on the person's total life span it is often possible to bring a new recognition to the relatively small period that disease has been a significant factor in the meaning of life. It is important to reinforce the view that a few years of illness cannot undermine 20, 30, 40, 50, 60, and even 70 years of constructive presence in the world. Having made the world a 'little better' through some work or the shared experience of love makes it all worthwhile. The gulf of meaning becomes bridged



through a restructuring of the priorities a patient gives to his or her accomplishments.

What about the people who, after frank consideration, believe that they have not had much to be positive about during any part of their past life? There seem to be so many people with malignant disease who have had one bitter disappointment after another, whose lives have not issued creatively in work or in relationships. Dr. Frankl mentioned that persons who are able to find some transcendent value in suffering are still able to find a meaning in the midst of apparent failure. In this context it has been my experience that it rarely happens that a patient will discover a new framework within which to find a value in suffering. In other words, death bed conversions are unlikely. However, it often is the case that a person already has a framework which has enabled him or her to cope with a lack of fulfillment and crises during the years and which can be brought into consciousness with a little prodding. Three kinds of examples come to mind:

1. Christians: If someone is a Christian then it is possible through an exploration of the meaning of suffering, and the offering of suffering, to reach a sense of the value of a free gift of personal circumstances to Christ and to the world.
2. Jews: If someone shares a feeling of Jewish identity then it is possible to understand suffering in the context of a collective experience which binds a people together in a common hope.
3. Agnostics or atheists: If someone understands life in terms of a personal struggle with and against natural forces, it is possible to give value to a stoical acceptance of life's inevitable end.<sup>4</sup>

8. Other religions: In a situation in which the patient practices a religion which is unfamiliar to the visitor it is possible to ask how that particular religion transcends suffering, for all of the great religious traditions have found a way to understand sickness and death.

The goal of the visitor here is to remind the person of the framework which worked for them before. Such questions as "How did you find the strength to withstand X in the past?" Or: "You obviously have a great deal of courage to have gone through X and still be able to smile a little, or be cheerful as you were a few minutes ago." In this way the person's focus is reoriented away from the failures and bitter disappointments of the past towards the personal strengths which were gained by passing through the experience and not becoming totally embittered or even imbalanced. It is important for the visitor to be truthful in the evaluation and not to praise what does not deserve it. The fact is, however, that everyone who has lived for several years has some things they have faced with personal strength, or at least from which they have gained strength afterwards. If they can find once more the source of that strength (whether God, being part of a people, or in the center of the self) it will help them to work through this final challenge.

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10a* → Dr. Koebler Ross mentioned in the First International Seminar on Terminal Care in Montreal 1976 that good atheists die as well as good Christians. She explained that this statement meant only that persons who had achieved an integration of the meaning of their lives often achieved a peace in terminal illness regardless of the nature of their particular meaning structure. The people who had the most difficulty were those who had not achieved an integration of meaning. It is possible, therefore, for an atheist to help a Jew,

or for a Roman Catholic to help an agnostic, or for a Jew to help a Protestant, etc. While the communication found in a shared religious framework leads to an immediate ground of exchange, it is possible to build a relationship when the religious frameworks are different. This can only occur, however, where there are other bases for a common ground. By approaching the patient in terms of exploring the differences, the person can be brought to a conscious articulation of his or her own philosophy. By using such questions as "How did you cope with life situations in the past? How can this framework help you now?", the basis for growth and integration is established. When, and only if the patient asks how you would find meaning in the same sort of circumstances <sup>should</sup> ~~can~~ you reveal your own framework. It is useful to add the advisory that "It may not be helpful to you because our basic life orientations are so different." This leaves the patient free from the fear of attempted conversion while at the same time opening up the possibility for learning about another way of understanding life's challenges. It is in the complementary relation of common ground and explored differences that the third stage of communication about meaning becomes possible.

### 3. The Mutual Release of Energies

So far the search for meaning has been discussed in a completely one-sided fashion. The visitor was described as bringing to the patient skills which might help someone with advanced malignant disease to bridge the gulf of meaning between his or her own past and present situation. Karl Jung in Modern Man's Search for a Soul recognized that the desire to find meaning is a deep urge found in everyone.<sup>5</sup> Therefore, the patient is not alone in this effort. There are two people involved and two struggles to find meaning. These two people are often at different stages of development. It can happen, and I might add that it frequently does happen, that the patient is far more inte-



grated than the visitor. In this case, it is the one who is ill that helps the one who is well in the struggle to find meaning.

It may be useful here to delineate four different models of personal development. These models concern the degree to which a person has developed a framework of meaning for his or her life and the direction and extent to which the dynamic energies which spring from a person flow from this framework.

#### A. Uncentered Person:

In this kind of person the energies are undirected. They seem to flow in a haphazard fashion. Ideas, feelings, moods occur without any particular pattern. There is no underlying meaning or philosophy of life. The person is fragmented and confused. It is almost impossible to build a relationship with such a person because there is no consistency to link up one visit with another. There may be an exchange of energy with this person, but the relation never seems to go anywhere.<sup>6</sup> *This description of the uncentered person is based on Kierkegaard's aesthetic man in Either/Or.*

#### B. Self-centered Person:

This kind of person is centered, but all the energies focus on the self. They may seem to be in relationship with you, but in fact all their thoughts, moods, and feelings float back to rest in a consideration of the self. They may even have a highly articulate meaning structure, but it does not go beyond itself. It is turned inward, locked in a prison of self love. While there might be an appearance of relationship nothing is really happening. There is no possibility of exchange of energies because little energy passes beyond the borders of the self.<sup>7</sup> *This description of the self-centered person is more like the higher men in Nietzsche's Thus Spoke Zarathustra or Raskin's In Sancho's Nausea.*

#### C. Other Centered Person:

Here the energies of the person are able to flow outward towards the world as well as inwards towards the self. ~~An example of such a person might~~

~~be found in Mother Theresa.~~ The other centered person becomes a continuous source of transformation for others. ~~This kind of effect can also be seen in the extraordinarily successful counselling of Dr. Koebler Ross in many situations of terminal care.~~ With the other centered person relationship is given almost immediately. It is sustained so that the self can be reoriented and developed into the fully integrated person it is capable of becoming.

*Gabriel Marcel describes his as the 'Disponibilité' or availability of a person in D. Combined Person: Itama Uiatun. Jaspers considers this quality as indispensable to friendship.*

Most of us and our patients do not fall into a single category listed above, but rather have a little bit of all three. We are partially uncentered, partially self-centered, and partially other centered. Our energies may correspondingly move outwards in chaotic or ordered sequences, or they may be turned inwards towards the self in equally chaotic or ordered patterns. The meaning structure for our life may be one day clear, and another day fuzzy, and another day hopelessly distant from our acts and words. One of the consequences of this combined self is that our interaction with others is rarely predictable. So many factors are in question. Fruitful interaction depends upon both persons being able to make contact with their 'other centered selves' at the same time. There is, therefore, always a sense of discovery in relationships. In exchanges about the meaning of life between visitors and patients it is not clear at all in the beginning who is helping whom. It is precisely this uncertainty that makes the situation so compelling and so humbling. The goal of the visitor, then, must be to make our 'other centered self' available to the patient.

*Then, and only then is it possible to move into the fourth stage of relationship.*

#### 4. The Creation of New Life

The creation of new life usually involves the combined efforts of two differentiated people in a relation of union. The paradigm of this creation is found in the relation of mother and father to child. In all sorts of situations,



however, something new and unexpected can be born from a union of two different persons. In the hospital setting this can occur when a patient and visitor realize that something more has flowed from their meetings than could have been anticipated. ~~One extraordinarily example of this creation of a new 'child' is found in the film about the Palliative Care Service entitled "Last Days of Living,"<sup>8</sup> The film-makers most likely entered the relationship with the desire to make a good film. The patients and families, with a multitude of different motivations probably hoped at the most to leave a part of themselves behind as a memory for others who knew them. The final creation of the interaction of these two different groups of people, however, became a powerful testimony of the deeper struggles to grasp the meaning of life and death. It will personally affect many people who never knew any of the original contributors.~~

~~The creation of new life in this unique film can be understood as a paradigm of all visitor-patient interactions.~~ Most of us have cherished memories of at least one relationship which was so fulfilling by the end that it was no longer aimed at change or understanding. Being together was enough. The original aim, to bridge the gulf of meaning, was surpassed by the spontaneous discovery that something 'more' had happened. In this 'something more' the original urge to be fruitful and multiply was fulfilled.

To briefly summarize the process as described above:

In the first place we are faced with two people, separate and distinct, with a combined framework of meaning and energy. The gulf of meaning gaps wide between its two perimeters.

Next, an attempt is made at building a common ground. The foundation for the bridge across the gulf is laid.

Then differences begin to be explored. The bridge becomes built so that passage is able to occur in both directions.



Either or both persons may be affected by a growth of level of integration and by the discovery of a renewed meaning structure which is satisfying and brings a certain inner peace. There is a constant possibility of travel back and forth. The gulf of meaning no longer seems important.

Finally, in certain situations something new is created by the relationship, something which goes beyond the original two people involved. At this moment not only has the bridge over the gulf of meaning been built, and used, but a union of the two perimeters for the bridge has brought forth a new entity. The bridge has assumed a life of its own.

This new life, when it occurs, is experienced as coming from outside, as a kind of grace. It cannot be predicted or controlled. In a sense it cannot even be worked for, as its presence is unexpected and known only 'after the fact.' We must not expect that the bridges we try to build will always or even often come alive. It is important to keep reminding ourselves in this particular work with serious illness and death that we are only able to lay the foundation for bridges. Insofar as we take responsibility for the quality of our own lives we will bring to the bridge-making a certain possibility of result. The ultimate nature of the bridge itself, however, will be determined by the mysterious interaction of the other persons involved. There is always a factor of spontaneity present in human life which can overturn all expectations. If we are open to this spontaneity as well as are prepared to listen and to give, then there is a chance that something important will occur in the mutual struggle to find meaning in our complex and compelling world.

I would like to finish this paper by adding a series of qualifications. If the presentation ended right now, there would be a danger that it would leave everyone with a set of unreal expectations. Instead of encouraging visitors to work towards bridging a gulf of meaning, it could lead to the opposite

If ~~often~~ happens that a person will want to read a philosopher or theologian who can reinforce their particular meaning structure at this point.

for example - Boethius, Consolation of Philosophy  
Marcus Aurelius - Meditations  
concerned for time with a stoical attitude

Ladislav Boros - for Christians.

Buber or Frankel - for Jews.

More often, however, a person is usually too tired to read - & he or she prefers either to be read to - or to listen merely to a paraphrase of a theory.

Sometimes I have even ventured Sartre's theory that death is the victory of other people. It usually gets a rather animated response.

situation in which everyone felt themselves to be failures because they had not been able to achieve this goal most, if not all, of the time.

Furthermore, the entire paper rests on the assumption that the patient and visitor share a common language and that discussions of a fair degree of sophistication are able to take place. We all know that in many situations in terminal care centers patients are frequently unable to speak because of the progress of the disease. Furthermore, in the paper called "Cultural Considerations in Palliative Care" Drs. Mount and Ajemian have demonstrated that language differences can create an obstacle to attempts at communication.<sup>9</sup>

In situations in which linguistic communication cannot occur the question of meaning must be approached through witness rather than words. The physical contact of the medical team in the precise way they approach the body of the patient, the careful use of non-verbal aids such as music and the visual arts, the care in selection and preparation of food, the determination to find and effect reconciliation with family members and friends--all these things communicate to the patient that the basic meaning structure found in our work with the seriously ill is one of care.<sup>10</sup> This kind of witness of care, <sup>which</sup> ~~in~~ <sup>analyzed</sup> ~~reflects Heidegger's theory in Being and Time~~ <sup>attention to details,</sup> as Dr. Cecily Saunders of St. Christopher's Hospice has so often said, constitutes the essence of what we are aiming to do. Therefore, we must evaluate our successes ~~not so much in terms of complicated theories or philosophies, but rather~~ <sup>in</sup> terms of the simple acts found in every day situations. It is these moments of witness that our choice of the meaning of life is revealed and the gulf of meaning between two people silently but firmly bridged.

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<sup>1</sup>Karl Jaspers, Philosophy, Vol. 2, Chapter 7.

<sup>2</sup>Elizabeth Loebler Ross, On Death and Dying.

<sup>3</sup>Viktor Frankl, Man's Search for Meaning.

<sup>4</sup>See for example: Marcus Aurelius, Meditations; Seneca, Moral Epistles to Lucilium, Boethius, Consolation of Philosophy, Nietzsche, Thus Spake Zarathustra, Camus, The Stranger, and The Plague. I would not necessarily recommend that you suggest to patients that they read these works, but rather that you can paraphrase significant thoughts contained within them in the context of the conversation.

<sup>5</sup>Carl Gustav Jung, Modern Man in Search of a Soul.

<sup>6</sup>Soren Kierkegaard, Either/Or.

<sup>7</sup>Pope John Paul, during his mass on the mall in Washington described many marriages as containing two persons filled with self-love living side by side.

<sup>8</sup>The film The Last Days of Living is available through the National Film Board of Canada.

<sup>9</sup>Dr. Ina Ajemian and Dr. Balfour Mount, "Cultural Considerations in Palliative Care" available on request from the Palliative Care Service, Royal Victoria Hospital, Montreal.

<sup>10</sup>Martin Heidegger describes the human condition as being-towards-care in Being and Time.

Any publication of the above books is acceptable.

The observations which became the basis for the philosophy of meaning in this paper came from questionnaires distributed to volunteers and staff on the Palliative Care Service as well as from my own experience as a volunteer.

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